



New Jersey Department of Children and Families Policy Manual

Manual:	CP&P	Child Protection and Permanency	Effective Date:
Volume:	X	Forms	
Chapter:	A	Forms	5-17-2010
Subchapter:	1	Forms	
Issuance:	11.4	CP&P Form 11-4, Consent for Operation, Treatment or Examination	

Click [here](#) to view or print the CP&P Form [11-4](#), Consent for Operation, Treatment or Examination.

Instructions 5-17-2010

PURPOSE AND USE

The form is used to:

- provide written evidence of CP&P's consent to a particular surgical procedure of medical treatment for a child under guardianship or legal custody or in voluntary or court ordered placement;
- document for the provider CP&P's authority to provide such consent;
- clarify the child's living arrangement for the provider and identify resource parents or other temporary caregivers who may be accompanying the child during the procedure.

The form is completed whenever a hospital or other medical services provider requests written consent as protection from litigation. Whenever possible, it is good case management practice to contact the child's parents to give the medical provider consent for examination and treatment of their child.

INSTRUCTIONS FOR COMPLETING THE FORM

The form is completed by hand and in duplicate by the Worker and signed by the Local Office Manager.

CONSENT

To	Enter the name of the physician/hospital caring for the child.
Address	Enter the address of the physician/hospital

	caring for the child.
(Treatment or procedures prescribed)	Enter the name or descriptive phrase describing treatment or procedure consented to e.g., tonsillectomy, appendectomy, physical examination, psychiatric examination, etc.
(Child's Name)	Enter the name of the child for whom medical care is authorized.
(Child's CP&P caregiver)	Enter the name of the child's resource parents, caregiver, or facility where the child is residing.
(Caregiver's address)	Enter the address of the resource parents, caregiver, or facility where the child is residing.

AUTHORIZATION

Date	Enter the date that the form is signed.
Signature	Enter the written signature of the Local Office Manager or designee.
Local Office	Enter the name of the Local Office where the child is receiving services.
Telephone Number	Enter the telephone number of the Local Office.

DISTRIBUTION

Original - Hospital/Physician/Health Professional
Duplicate - Child's record